COMPLAINT COMMITTEE OF THE
WEST VIRGINIA BOARD OF MEDICINE

101 Dee Drive, Suite 103
Charleston, West Virginia 25311
(304) 558-2921

Complaint Questionnaire

Please complete the following information concerning your complaint. Please attach any photocopies of documents, including medical records if available, that are pertinent to your complaint. State in detail all facts which you believe justify your complaint. If possible, state whether the information is within your personal knowledge, and if not, the source or sources of the information. (PLEASE PRINT OR TYPE)

1. Name of Complainant _____
   Address _____
   _____ Phone_____

2. Complaint Against (First and Last name) _____
   Address _____
   _____ Phone _____

3. Additional Information Required
   a. What is the date that the practitioner cared for you? _____

   b. Did any individual(s) treat you after the alleged incident? _____
      If so, please specify name(s) and address(es) _____
      _____
      _____

   c. Were you an inpatient or outpatient of any health care institution after or during the alleged incident? _____
      If so, please specify name(s) and address(es) _____
      _____
      _____
      _____

   d. Have you contacted the practitioner about your complaint? _____
      What action was taken? _____
      _____

   e. Have you filed this complaint elsewhere? _____
      If so, please specify _____
      What action was or is being taken? _____
      _____

   f. If necessary, do you consent to the release of your medical records?
      _____

Please describe your complaint in detail (attach an extra sheet if necessary)

PLEASE NOTE: In order to insure procedural due process, it will be necessary that we forward this complaint to the practitioner in question to be of assistance to you. **YOUR SIGNED COMPLAINT IS A MATTER OF PUBLIC RECORD.**

I certify that the above information is true to the best of my knowledge. I further state that I will voluntarily appear and testify to the facts in this complaint if called upon by the West Virginia Board of Medicine.

DATE _____SIGNATURE OF COMPLAINANT _____